

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

28081

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **003**

City **St. Louis**

(No. **Alx Bros Hospital**)

File No. **7162**

Registered No.

St. Ward)

2. FULL NAME **Antonia Pessoni**

(a) Residence, No. **1420 Monty Ave** St. **24** Ward. **St. Louis County, Mo**
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Victoria Pessoni**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Unknown**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
About 52

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Day Laborer**

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Italy**

13. NAME **Char Pessoni**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Italy**

15. MAIDEN NAME **Not known**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Italy**

17. INFORMANT **Angela Pessoni**
(ADDRESS) **1420 Monty Ave**

18. BURIAL, CREMATION, OR REMOVAL PLACE **S. S. Pater Paul** DATE **Aug 21** 19. **32**

19. UNDERTAKER **Donnelly, Fred B**
(ADDRESS) **7819 34th St. St. Louis**

20. FILED **Aug 19 1933** 19. **J. T. Bridgick**
Registrar.

2

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **8-17-33**

22. I HEREBY CERTIFY, That I attended deceased from **8-5-33** to **8-17-33**, 19. **33**

I last saw him alive on **8-17-33**, 19. **33** Death is said

to have occurred on the date stated above, at **11:15 p.m.**

The principal cause of death and related causes of importance were as follows:

Broncho pneumonia Date of onset **8-10**

82A
107A

Other contributory causes of importance:
Cerebral hemorrhage **7-7**

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **no**

If so, specify.....

(Signed) **Edmond Pessoni**, M. D.

(Address) **1703 So. Grand**

